

### BLOOD DONOR QUESTIONNAIRE

<b>Name:</b>	degree:	<b>Date:</b>
<b>Birth Register Number:</b>		Number of arrival:

Please fill in the data below responsibly and completely. **Circle the correct answer!**

Please read carefully the **“BLOOD DONOR INSTRUCTIONS”** before filling the questionnaire in.

1. Have you acquainted with the information about risk behavior from the point of view of blood donation and do you understand it ? ..... yes no
2. Do you belong to a group permanently excluded from blood donation ? ..... yes no  
(Stay in Great Britain or France in 1980-96 for more than 6 months; treatment with human growth hormone or other medicaments proceeding from the hypophysis or salivary glands; surgery with the use of a dura mater graft; transplantation of the cornea or the tympanum; classical or variant Creutzfeldt-Jakob disease in you or among your blood relatives; practicing sex between men; application of intravenous / intramuscular drugs.... see “BLOOD DONOR INSTRUCTIONS”)
3. Are you going to donate blood or its components for the first time ? ..... yes no
4. Do you tolerate blood taking well ? ..... yes no
5. Do you donate in another medical facility ? ..... yes no
6. Have another transfusion department ever refused you as a blood donor ? ..... yes no  
Reasons: .....
7. Does your profession or hobby require increased physical exercise or demands for attention ? ..... yes no  
(professional driver, pilot, work in heights, mountaineering, diving, etc.)

#### CURRENT HEALTH CONDITION

8. Do you feel healthy ? ..... yes no
9. Do you take any medicaments regularly ? ..... yes no  
(please cite all of them, including e.g. aspirin, oral contraception)  
What: .....
10. Have you taken any medicaments during the last 4 weeks ? ..... yes no  
What: .....
11. Do you sweat excessively during night, do you observed elevated temperature, swollen nodes? .. yes no
12. Have you been losing weight recently without any obvious cause ? ..... yes no
13. Are you treated or observed for any disease (including infections) ? ..... yes no
14. Have you suffered any disease during the last 4 weeks (cold, diarrhea etc.) ? ..... yes no
15. Have you undergone tooth extraction or a minor surgery during the last 7 days ? ..... yes no
16. Have you had a tick bite during the last 4 weeks ? ..... yes no

#### CHANGES IN THE HEALTH CONDITION

17. Have you undergone **during the past 6 months:**
  - a. A surgery, injuries treated in a hospital, stay in a hospital, intravenous application of medicaments ? ..... yes no
  - b. Endoscopic examination or introduction of a catheter, contact with another. person’s blood (through an injury or mucous membrane) ? ..... yes no
  - c. Transplantation, or have you received blood transfusion ? ..... yes no
  - d. Treatment for a venereal disease ? ..... yes no
  - e. Tattooing, acupuncture, ears perforation, piercing ? ..... yes no
  - f. Vaccination ? ..... yes no
 If yes, what and when: .....
18. Have you been in a close contact (in the family, at work) with a patient suffering hepatitis, AIDS, another infectious disease, or with a person abusing intravenous / intramuscular drugs ? ..... yes no  
What disease: .....
19. Have you traveled abroad during the past 6 months ? ..... yes no  
Where? (Including for a short time, tourism): .....
20. Do you work in dangerous environment (infectious, harmful to death) ? ..... yes no  
What (infection, radiation, chemical risks etc.) ? .....
21. Have you been vaccinated against rabies or type B hepatitis after exposure to infection? ..... yes no

